

tremely useful is not infallible. Ordinarily a new growth produces a roughly circular shadow, which may originate either in the parenchyma or hilum, may or may not be circumscribed, and may be accompanied by smaller metastatic shadows. Multiple tumors usually cast larger shadows than tuberculosis, and the surrounding lung is clearer. Secondary carcinosis shadows are likely to be most thickly set at the base. The growth may show only as a haziness and x-ray evidence may even be entirely lacking, though it is rare to have negative findings when symptoms are present. If effusion is found, it should be aspirated and x-ray study made at once. A diagnostic pneumothorax may prove helpful. In doubtful cases of mediastinal shadow the esophagus may be filled with barium for screen study. Misleading conditions include intrathoracic thyroid, enlarged thymus, actinomycosis, nocardiosis, hydatid disease, encysted empyema, abscess, cold abscess, unresolved or caseous pneumonia, lung syphilis and aneurism. Benign lung tumors are rare, so the differentiation is mainly between carcinoma, sarcoma, lymphosarcoma, endothelioma, and Hodgkin's disease.

A few cases of successful surgical removal of lung tumors have been reported. Roentgen therapy has prolonged life for years in lymphosarcoma and Hodgkin's disease, even bringing apparent cure, and in cancer has produced a few favorable results. With deep therapy now in wider use, the outlook is brighter. Radium externally and bronchoscopically applied, was successful in one case. Among general remedies, selenium and copper have been used abroad with some success. A promising method is the intravenous use of lead, but this preparation is not yet obtainable for general use. For cancer, colloidal gold, and for sarcoma, Coley's fluid, merit trial, and thyroid therapy and iodides should not be disregarded. Potash, up to 90 to 180 grains a day, is also worthy of use. Many are accepting the view that there is some general predisposing factor, and cancer is rare among peoples who use no meat. A meatless nonstimulating diet in moderate quantity only should be advised, and intestinal stasis prevented.

Four cases, one primary carcinoma, one primary sarcoma with tuberculosis, one unidentified tumor which disappeared under thyroid therapy, and one probable primary carcinoma engrafted on tuberculosis and associated with syphilis, are cited.

The outlook is no longer hopeless, and with concentrated efforts it seems that in future years a not inconsiderable number of these patients will be saved.

Enormous Calculus Pyonephrosis—The case reported by Montague L. Boyd, Atlanta, Ga. (Journal A. M. A.), illustrates how painless an enormous enlargement of the kidney with very large calculi may be and the difficulty encountered at operation in such a condition. In this particular case an intracapsular enucleation of the kidney was done. The entire mass measured about 20 by 20 by 35 cm.; the decapsulated kidney, about 18 by 18 by 30 cm. It was lobulated, fairly firm, and uniformly enlarged. It weighed 196 gm. The stone paste weighed much more than that. Microscopic examination showed a mass of connective tissues with acute inflammatory processes and only an occasional glomerulus. The diagnosis was pyelonephritis, chronic and acute, and renal calculus.

CLINICAL NOTES, CASE REPORTS AND NEW INSTRUMENTS

SUPRARENAL HEMORRHAGE

REPORT OF A CASE IN A NEW-BORN CLINICALLY RESEMBLING INTRACRANIAL HEMORRHAGE

By ESTHER BRIDGMAN CLARK *

(From the Division of Pediatrics, Stanford University Medical School, San Francisco, California.)

The occurrence of hemorrhage of the suprarenal gland in the new-born was first described by Mattei¹ in 1863, when he noted it in a statistical report of autopsy findings in fetuses and new-borns. Bilateral hemorrhage is more common than unilateral, but when the latter occurs the right kidney is more often involved than the left. It is more common in girls than boys.

Hamill² (1901) gives a very detailed review of the literature and 90 case reports from the literature and his own observation. Corcoran and Straus³ (1924) also review the literature and note that about 100 cases have been reported. They add a case of their own in which the diagnosis of suprarenal hemorrhage was made in a five-day-old infant. Operation was performed, the hematoma removed and a bleeding point on the suprarenal ligand ligated. Complete recovery ensued.

The etiology is obscure and is most likely not the same in all cases. Those hemorrhages occurring in stillborns or very soon after birth are considered by Rabinowitz⁴ (1923) as being due to asphyxia. Corcoran and Strauss³ also believe that in new-borns trauma and asphyxia play the most important rôles, the suprarenals being of very friable tissue and rich in blood vessels.

Some cases appear to be associated with sepsis, the blood culture having been found to be positive. Other causes that have been suggested are syphilis, hemophilia, thrombosis of the suprarenal veins, and compression of the vena cava by the liver.

Langlois and Chanin⁵ (1893) produced engorgement of the suprarenal in rabbits by injecting *B. pyocyaneus*, Roux and Yersin⁶ (1899) got the same result with *B. diptheriae*.

Many of the cases are associated with purpura, especially in older infants and young children. The possibility of the purpura bearing the same relation to the suprarenal hemorrhage that pigmentation of the skin bears to the diseased suprarenal in Addison's disease has long been considered.

The symptoms are variable, but for the most part resemble those of an internal hemorrhage. There is rapid shallow breathing, air hunger, restlessness, refusal to nurse, vomiting, fever, frequent convulsions, at times an increasing anemia is noticeable. In a few infants in whom the hemorrhage is very extensive the mass has been palpated. The colon may be compressed with symptoms of intestinal obstruction. In male infants swelling of the scrotum has been noted from pressure on the left spermatic vein in hemorrhage of the left suprarenal. In practically all of the cases reported sudden onset in previously normally behaving infants or children is the rule.

CASE REPORT

From the service of the Children's Clinic, Lane Hospital. Baby girl S., No. 151119. Born April 28, 1926, at 7:30 p. m. Parents were each 22 years old and healthy. The mother was a primipara and had a normal pregnancy terminating at term in an easy, normal, five-hour

* Esther Bridgman Clark (Lane Hospital, San Francisco). M. D. Stanford University, 1925; A. B. Stanford, 1921. Graduate study: Senior Intern in Pediatrics, Lane Hospital, 1925-26. Present hospital connections: Resident in Pediatrics, Lane Hospital. Scientific organizations: Northern California Pediatric Association; San Francisco County Medical Society, C. M. A., A. M. A. Practice limited to Pediatrics.

labor. Her Wassermann was negative. The baby was well developed and weighed 3680 gms. Cry was delayed for 20 minutes, then breathing was irregular and shallow, though the pulse was good. Bleeding time was $1\frac{1}{2}$ minutes, coagulation time 3 minutes; however, 10 cc. of whole blood was given intramuscularly. After four hours, breathing became normal. April 29 at 9 a. m. temperature was 100.2 R. (had been over lights). Refused to nurse. At 2 p. m., after taking 20 cc. at breast, regurgitated and had a cyanotic attack lasting a few minutes. April 30, at 2 a. m., began having generalized convulsions lasting a minute and occurring every 15 to 30 minutes. At 8 a. m. there was moderate cyanosis, breathing shallow and irregular, frequent convulsive twitchings of arms, hands, and legs. The fontanelle was rounded out but not tense. The possibility of intracranial hemorrhage was thought of and lumbar puncture done. Clear fluid under no increase of pressure was obtained; it showed 140 red blood cells per cu. mm., mostly old. Respirations continued slow, irregular, and shallow. There were frequent severe attacks of cyanosis, slightly relieved by oxygen. By 6 p. m. the baby was constantly limp and the pulse was 70-80 per minute, and irregular. Death occurred at 11:20 p. m. (Age 52 hours.)

Clinical Diagnosis—Multiple cortical hemorrhages.

A necropsy was done ten hours after death by Doctor William Ophüls. There was no evidence of subdural or intracranial hemorrhage, the meninges and brain were congested. Icterus neonatorum was present. There was a small amount of sticky, bloody fluid at the base of the right pleural cavity. The right adrenal gland was almost totally destroyed by a large hemorrhage; the hemorrhagic mass measured $3 \times 2 \times 1$ cm. The right kidney and left adrenal and kidney were normal. There were no other significant findings.

Anatomical Diagnosis—Hemorrhage of adrenal, right; icterus neonatorum.

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GIANT URTICARIA DUE TO DISEASED (PUS) TONSILS

CASE REPORT

By SAMUEL FLOERSHEIM, M. D., Los Angeles

A male patient in a tuberculous sanitarium was referred to me suffering from giant urticaria.

The history elicited the fact that three months previously spiced chopped fish was served with other foods. Most all persons who had partaken of this fish became more or less decidedly ill. The medical director and assistants did not eat any and they were not attacked.

The patient was first referred to a dermatologist, who tried every means known to him to control the attacks. The patient during these three months was also sent to and examined by the nose and throat specialist. The patient came to me with no improvement and with the decision that the tonsils should come out, as they may be a factor in the constancy of the attacks. The patient never before suffered with the attacks of urticaria and he was not seemingly ill with his pulmonary tuberculosis. He was rated as a good case, just past the incipient stage—not apparently quiescent—practically no cough or expectoration. Going over him quite thoroughly, even to x-rays and general laboratory work, nothing of especial note was encountered except some intestinal non-pathological parasites (Brem-Zeiler). He was vigorously

treated for this with no apparent good results. Abstinence from food and with very little water for two days would prevent the occurrence of attacks. These attacks would occur chiefly after midnight and would wane after 6 or 7 a. m. At times the urticarial lesions would persist until noon. Any and every food would cause attacks. He was protein tested for all and every food, dust, hair pollens, etc., some 180 or more in number by both a special physician in protein sensitization and at the Los Angeles General Hospital—all negative. To me the tonsils did not seem seriously diseased, and I believe bacterial protein was also used in the test and found negative. After all the different tests and varied medication, diet, and hygienic measures were advanced and carried out, no progress was made. It was proposed to try a cool climate, and in the event of failure then as last resort to have a complete tonsillectomy performed. The patient left presumably for San Francisco or Portland, but turned up in Denver late in October or November. He was gone over very carefully and thoroughly again and the decision was not to do a tonsillectomy, but to do autohemetic therapy. This likewise proved futile. All the while the patient did not lose much weight nor did his pulmonary tuberculosis progress nor did he feel very ill except only at the irregular time of outbreaks of the giant urticaria. After definite autohemetic failure, nothing else left to experiment with and with the former suggestions of last resort of tonsillectomy, the patient asked and fairly insisted on trying out the operation.

Letter received from him four weeks after the operation stated: "I feel 90 per cent better and hope the other 10 per cent will follow soon." Four months later another letter received in which the information was advanced that the other 10 per cent had been accomplished. Eight months later I again interviewed the patient and he explicitly stated that not a single attack of urticaria has appeared since the day of the tonsillectomy—eighteen or twenty months—in spite of the fact of his numerous attempts to bring on an attack by eating allspice, onions, horseradish, pickles, fish, condiments, and any and all irritating foods.

FOREIGN BODIES IN THE ALIMENTARY TRACT

By W. C. SHIPLEY, M. D.

During the past twenty-six years it has fallen to my lot to give advice to many mothers whose children have swallowed small toys and other objects foreign to the digestive system. The list includes marbles, small metal toys, buttons, screws, wire nails, tacks, pins, nickles, dimes, copper cents, small pieces of rags, rubbers, and other objects that have slipped my memory.

As my first experience with this line of work was in a mountain district where there were no hospital facilities or x-ray to aid in the diagnosis, and as something had to be done to appease the anxiety of the parents, especially the mothers, the following line of treatment always served to bring the offending object safely through the alimentary canal in from twenty-four to thirty-six hours without harm to the patients who, in most instances, were children under 6 years of age.

Give the patient all the canned corn or beans that he will eat. This forms an indigestible mass about the object to be removed and at the same time acts as a skid to help it on its way through its tortuous passage. About two hours later a good dose of castor oil is administered, and the mother told to watch every stool that the child passes until the object is found. This line of treatment, while it may seem crude, is simple, safe, and sure.

Simple Goiter and Its Prevention—According to David Marine, New York (Journal A. M. A.), the factors which cause simple goiter center about the supply of iodine and the needs, normal and abnormal, of the thyroid gland for iodine. Supplying this element in amounts that can be considered as roughly approximating the physiologic needs of the body has resulted in completely controlling the disease both in man and in animals.